TUMOR REGISTRY RULES

Administrative Rules of Montana

Subchapter 18

Tumor Registry

37.8.1801 REPORTABLE TUMORS (1) The following tumors are designated as reportable:

(a) malignant neoplasm, with the exception of a basal or squamous carcinoma of the skin;

(b) skin cancer of the labia, vulva, penis or scrotum;

(c) benign tumor of the brain, including a:

(i) meningioma (cerebral meninges) ;

(ii) pinealoma (pineal gland) ; or

(iii) adenoma (pituitary gland) ;

(d) carcinoid tumor, whether malignant, benign or not otherwise specified (NOS) .

(2) A benign tumor other than one of those listed in (1) may be reported to the department for inclusion in the tumor registry if prior approval has been obtained from the Department of Public Health and Human Services, Public Health and Safety Division, Montana Central Tumor Registry, 1400 Broadway, PO Box 202951, Helena, MT 59620-2951.

(3) A tumor which is otherwise reportable, but has been diagnosed and recorded using the words "questionable", "possible", "suggests" or "equivocal" is not considered a reportable tumor.

(4) Whenever records of a patient with a tumor which would be reportable, if confirmed, contain the words "suspect", "probable", "suspicious", "compatible with" or "consistent with" in reference to that tumor, the tumor is considered reportable.

(5) In order for the department to maintain current reporting, hospitals shall submit to the department information on reportable tumors within six months from the date of discharge; independent laboratories shall submit to the department information on reportable tumors within six months from the date the laboratory service associated with the tumor was rendered. (History: Sec. 50-15-706, MCA; IMP , Sec. 50-15-703, MCA; NEW , 1982 MAR p. 391, Eff. 2/26/82; AMD , 1985 MAR p. 1857, Eff. 11/30/85; AMD , 1988 MAR p. 726, Eff. 4/15/88; TRANS , from DHES, 1997 MAR p. 1460; AMD , 2003 MAR p. 2441, Eff. 10/31/03.)

37.8.1802 REQUIRED RECORDS, INITIAL ADMISSION AND TREATMENT (1) Whenever a hospital initially provides medical services to any patient relating to a tumor designated as reportable by ARM 37.8.1801, it must collect, record and make available to the department the following information about that patient:

(a) name and current address of patient;

(b) patient's address at time of diagnosis;

(c) social security number;

(d) name of spouse, if any;
(e) phone number;
(f) race, sex, marital status and religion (optional) ;
(g) age at diagnosis, place of birth and month, day and year of birth;
(h) name, address and phone number of friend or relative to act as contact, plus relationship of that contact to patient;
(i) date and place of initial diagnosis;
(j) primary site of tumor (paired organ) ;
(k) sequence of primary tumors if more than one;
(l) other primary tumors;
(m) method of confirming diagnosis;
(n) histology, including dates, place, histologic type and slide number;
(o) summary staging, including whether in situ, localized, regional, distant or unstaged, with no information;
(p) description of tumor and its spread, if any, including size in centimeters, number of positive nodes, number of nodes examined and site of distant metastases;
(q) whether American joint committee on cancer (AJCC) staging is utilized, and if so, the findings of the staging;
(r) cumulative summary of all therapy directed at the subject tumor, including:
(i) date of therapy;
(ii) specific type of surgery or radiation therapy, if any; and details of chemical, hormonal or other kinds of treatment; and
(iii) if no therapy given, reason for lack of therapy;
(s) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence or recurring or status unknown;
(t) if recurrence of tumor, type and distant sites of first recurrence;
(u) names of physicians primarily and secondarily responsible for follow up;
(v) date of each follow up; and
(w) if patient has died, date of death, place, cause and whether autopsy performed. (History: Sec. 50-15-706, MCA; IMP , Sec. 50-15-703, MCA; NEW , 1982 MAR p. 391, Eff. 2/26/82; TRANS , from DHES, 1997 MAR p. 1460; AMD , 2003 MAR p. 2441, Eff. 10/31/03.)

37.8.1803 REQUIRED RECORDS, FOLLOW UP (1) Whenever a patient for whom information has been provided to the tumor registry is admitted to the hospital providing the information on an inpatient or outpatient basis for further treatment related to the tumor for which original registration in the tumor registry was made, the hospital must keep on file the following information:
(a) patient's name, noting any change from previous records;
(b) any paired organ involvement, noting sequence;
(c) subsequent histology, including dates, place, histology type, slide number and procedure;
(d) date, type of procedure and findings of any surgery or other exploratory measure;
(e) date and type of any administration of radiation;
(f) date of any administration of hormones, chemotherapy, immunotherapy or any other kind of treatment;

(g) date of death and/or last follow up;

(h) if death has occurred, the place, cause and whether an autopsy was performed;

(i) if autopsy performed, its findings pertaining to cancer;

(j) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence or has recurred or status is unknown;

(k) if recurrence of tumor, type and distant sites of first recurrence; and

(l) names of those physicians primarily and secondarily responsible for follow up treatment. (History: Sec. 50-15-706, MCA; IMP , Sec. 50-15-703, MCA; NEW , 1982 MAR p. 391, Eff. 2/26/82; TRANS , from DHES, 1997 MAR p. 1460; AMD , 2003 MAR p. 2441, Eff. 10/31/03.)

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37.8.1808 REQUIRED RECORDS, INDEPENDENT CLINICAL LABORATORIES (1) Whenever a clinical laboratory which is not owned or operated by a hospital provides laboratory services for any patient relating to a tumor designated as reportable by ARM 37.8.1801, it must collect, record and make available to the department the following information about that patient:

(a) name and current address of patient;

(b) patient's address at time of diagnosis;

(c) social security number;

(d) name of spouse, if any;

(e) race, sex and marital status;

(f) age at diagnosis, month, day and year of birth;

(g) date and place of initial diagnosis;

(h) primary site of tumor (paired organ) ;

(i) sequence of primary tumors, if more than one;

(j) method of confirming diagnosis;

(k) histology, including dates, place, histologic type and slide number;

(l) summary staging, including whether in situ, localized, regional, distant or unstaged, with no information;

(m) description of tumor and its spread, if any, including size in centimeters, number of positive nodes, number of nodes examined and site of distant metastasis;

(n) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence or recurring or status unknown; and

(o) names of physicians primarily and secondarily responsible for follow up. (History: Sec. 50-15-706, MCA; IMP , Sec. 50-15-703, MCA; NEW , 1985 MAR p. 1857, Eff. 11/30/85; TRANS , from DHES, 1997 MAR p. 1460; AMD , 2003 MAR p. 2441, Eff. 10/31/03.)